Pharmacy

Prior Authorization Criteria for New Users of Xifaxan 550 mg

Background

The GI-2 antibiotics are used to treat travelers' diarrhea, hepatic encephalopathy and *Clostridium difficile* infection. Agents in this class include metronidazole (Flagyl, generics), vancomycin (Vancocin, generics), rifaximin (Xifaxan), fidaxomicin (Dificid), nitazoxanide (Alinia) and neomycin (Neo-Fradin, generics).

The following criteria were established by the DoD Pharmacy & Therapeutics (P&T) Committee. These criteria have an automated component, based on review of prescriptions filled using the DoD pharmacy benefit at retail network pharmacies, military treatment facilities, or the Mail Order Pharmacy.

Prior Authorization Criteria for New Users of Xifaxan 550 mg for Hepatic Encephalopathy

Coverage for Xifaxan 550 mg will be approved if the patient meets the following criteria:

1. Documented use in hepatic encephalopathy

Coverage for Xifaxan 550 mg tablets is NOT approved for the following conditions: Travelers' diarrhea, *C. difficile* infection, irritable bowel syndrome, inflammatory bowel disease, chronic abdominal pain, hepatitis, diabetes, rosacea, and any other non-FDA approved use

Criteria approved through the DoD P&T Committee process

www.tricare.mil is the official Web site of the
Defense Health Agency,
a component of the Military Health System
DHHQ, 7700 Arlington Blvd,
Falls Church, VA 22042

Prior Authorization Request Form for
rifaximin (Xifaxan®) 550 mg

6004

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE Mail Order Pharmacy (TMOP) *OR* the TRICARE Retail Pharmacy Program (TRRx). Express Scripts is the TMOP and TRRx contractor for DoD.

MAIL ORDER and RETAIL	• The provider may **call**: **1-866-684-4488** or the completed form may be **faxed** to: **1-866-684-4477** • The patient may attach the completed form to the prescription and **mail** it to: **Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954** or **email** the form only to: **TpharmPA@express-scripts.com**

Prior authorization criteria and a copy of this form are available at: **http://pec.ha.osd.mil/forms_criteria.php.** This prior authorization has no expiration date.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Will this medication be used for treatment of hepatic encephalopathy?	☐ Yes Sign and date below	☐ No Coverage not approved†

† Coverage is NOT provided for the treatment of other conditions not listed above, including: traveler's diarrhea, C. difficile infection, irritable bowel syndrome, inflammatory bowel disease, chronic abdominal pain, hepatitis, diabetes, rosacea, or any other non-FDA approved use.

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date

[15 May 2013]